

Gulfview Heights Primary School OSHC

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Working together to reach new Heights



Enrolment Form

CHILD DETAILS

CASUAL/PERMANENT

FAMILY NAME _____ FIRST NAME: _____

PREFERRED NAME: _____ GENDER: MALE/FEMALE

DATE OF BIRTH: ____/____/____ CRN: _____

RESIDENTIAL ADDRESS: _____

TOWN/SUBURB: _____ POSTCODE: _____

PRIMARY LANGUAGE SPOKEN AT HOME: _____

DOES THE STUDENT IDENTIFY AS BEING OF ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT?

No Yes, Aboriginal Descent Yes, Torres Strait Islander Descent

IS THE CHILD IN STATE CARE? No Yes

Enrolling Parent/Guardian Information (Account Holder)

Name: _____ Relationship to child: _____ D.O.B: _____

Address: _____ Postcode: _____

Home Phone: _____ Mobile Phone: _____ Work: _____

Place of employment: _____

Email: _____ CRN: _____

Parent/Guardian Details

Name: _____ Relationship to child: _____ D.O.B: _____

Address: _____ Postcode: _____

Home Phone: _____ Mobile Phone: _____ Work: _____

Place of employment: _____

Email: _____

Custody Issues/Court Orders (if applicable)

If parents are separated or divorced: Does the child have contact with both parents? Yes/No
 Is anyone legally denied access to the child? Yes/No

If there are court orders in place or any legal documentation relating to the custody of the children please provide a copy of this information with your enrolment.

Emergency Contacts (if parents are un-contactable and must be over 18 years of age)

Contact 1		
Name:	Relationship to Child:	
Address:	Postcode:	
Home Phone:	Work Phone:	Mobile Phone:

Contact 2		
Name:	Relationship to Child:	
Address:	Postcode:	
Home Phone:	Work Phone:	Mobile Phone:

NOTE: It is very important you tell these people that you have nominated them. In nominating them, you give them authority to act on your child’s behalf if neither parent/guardian can be located to pick up the child in an emergency and care for the child until he/she can be returned home.

Other adults authorised to collect child:			
1	Name:	Mobile:	Relationship to child:
2	Name:	Mobile:	Relationship to child:

NOTE: The people nominated here have been given approval only to collect the child and should NOT be contacted in case of an emergency.

Medical Information

Child’s Name:	Type	Please Provide:
Allergies: if your child is required to take medication in the case of an allergic reaction, please complete a Medical Management Plan (Additional forms required) Yes No		<ul style="list-style-type: none"> • An Action Plan • A Risk Management Plan • Medical Conditions Communication Plan
Disabilities: Does your child have physical limitations or a medical condition. Please provide details Yes No		<ul style="list-style-type: none"> • An Action Plan • A Risk Management Plan • Medical Conditions Communication Plan
Emotional/Behavioural Problems Yes No		<ul style="list-style-type: none"> • An Action Plan • A Risk Management Plan • Medical Conditions Communication Plan
Special Diet Yes No		<ul style="list-style-type: none"> • An Action Plan • A Risk Management Plan • Medical Conditions Communication Plan
Asthma and use of puffers – if your child is required to take medication in the case if an asthma attack, please complete Yes No		<ul style="list-style-type: none"> • An Action Plan • A Risk Management Plan

an Asthma Risk Management Plan. (Additional forms required)		<ul style="list-style-type: none"> • Medical Conditions Communication Plan
Medications – if your child is required to take medication at OSHC a Medical Management Plan is required before the enrolment can be processed. (Additional forms required – please see Director)	Yes No	<ul style="list-style-type: none"> • An Action Plan • A Risk Management Plan • Medical Conditions Communication Plan
Other Medical	Yes No	<ul style="list-style-type: none"> • An Action Plan • A Risk Management Plan • Medical Conditions Communication Plan
Cultural/Religious Requirements	Yes No	
Immunisations up to date (including COVID vaccinations)? (Please supply a copy of Immunisation records)	Yes No	<ul style="list-style-type: none"> • A copy of immunisation records

NOTE: Please supply the service with required medications in original containers with the child's name clearly marked. Please complete a permission to administer medication form where necessary.

Medicare Number: _____ Health Care Card Number: _____

Private Health/Medical Benefits Cover with: _____ Ambulance Cover? Yes/No

We aim to provide inclusive quality care for a range of children from differing cultures and backgrounds. Please share with us a little of your family's background information so we can incorporate this within our program.

Booking Form

Please indicate your required OSHC bookings on the table below

Before School Care	Monday	Tuesday	Wednesday	Thursday	Friday
6.30am – 8.35am					
From ____ / ____ / ____ Until ____ / ____ / ____ Ongoing permanent bookings Yes/No					

After School Care	Monday	Tuesday	Wednesday	Thursday	Friday
3.10pm – 6.30pm					
From ____ / ____ / ____ Until ____ / ____ / ____ Ongoing permanent bookings Yes/No					

I have no regular times at this stage – I would like to use the service on a casual basis.
 What date will your child commence? _____

Parent/Guardian

I agree to the terms and conditions of the above. Please sign below.

Print name: _____

Signature: _____

Date: _____

Office Use Only

1. CRN	
2. D.O.B	
3. Bookings	
4. Email address	
5. OSHC Medical Plans received	
6. Hat	
7. Folder	
8. Birthday Chart	
9. Programming	
Entered by:	
Date:	